

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6608-62-028637
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

FILED JUL 31 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN **ST LOUIS**

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MO

b. COUNTY

Inside Limits

Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location).
HOSPITAL OR INSTITUTION

4150 ST. FERDINAND

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)

4150 ST. FERDINAND

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED

First

Middle

Last

JOSEPH

FOSTER JR.

4. DATE OF DEATH

Month

Day

Year

6-30 1962

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. Married ☒ Never Married ☐

Widowed ☐ Divorced ☐

8. DATE OF BIRTH

5-14-1910

9. AGE (last birthday)

52

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

MISS.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

JOSEPH FOSTER

13b. MOTHER'S MAIDEN NAME

ELIZABETH

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

6 DELORIS DAVIS 4714 MAFFITT

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary occlusion

Arteriosclerosis

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from _____, to _____ and last saw her alive on _____

Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

Paul J. Simon Deputy Coroner

Bob Clark

7/5/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

REMOVAL

7-5-1962

GREENWOOD

St Louis Co

MO.

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

LOUE UNDERTAKING CO. 3103 WASHINGTON

JUL 5 1962

Paul Smith M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

1

2 **21/1**

3

4 **2**

5 **1**

6

7 **1**

8 **2**

9

10

11

12 **90-3**

13

90

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. No Embalming
P. O. Address Love Undertaking Co.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.